

1       49.     The December 8, 2005, memorandum provided the "Administrative position on Open  
2 Access to Patients." It directed that no patient was to be turned away by Admissions' Nurses. If one of  
3 the Admissions nurses considered "turning down services for a referred patient" she was to call the  
4 medical officer of the day ("MOD"). That call and the directive given by the MOD had to be docu-  
5 mented in the computerized system used by SDH known as "MISYS." This same procedure was to be  
6 employed any time that an admissions registered nurse considered declining any type of treatment  
7 prescribed for the patient.

8       50.     The December 8, 2005 memorandum directed:

9             The Admission RN, Program Rep, or Intake Specialist will always keep  
10            "yes" at the forefront while speaking with and/or assessing any patient  
11            referred to SDH. If there is an inclination to say "no" to anything (i.e:  
12            admission, treatment) a consultative call will be made to the MOD Doc/  
13            Physician on-call and documented in the Misys clinical notes of the  
14            patient.

15       To achieve this "yes" attitude, the MOD doctor virtually always ordered admission. Assess-  
16       ments were also falsified by staff who feared that they would be sanctioned or terminated if they  
17       refused to conform to the fraudulent scheme.

18       51.     MOD calls consistently resulted in the admission of the unqualified patients and the  
19       provision of questionable and curative services.

20       52.     The admission of patients who did not qualify under Medicare or Medicaid was  
21       accomplished through another manipulation of admission standards. While many hospice facilities  
22       and physicians rely upon the Karnofsky Index Score and Functional Status scores to determine whether  
23       the patient is near the end of life (to meet the less than 6 months of life remaining criteria), SDH's  
24       medical director rewrote these standards so that nearly every patient would qualify.

25       53.     Patients were also admitted who did not want to forego curative medicine and who  
26       wanted to undertake aggressive treatment to prolong their lives. These patients did not meet hospice  
27       eligibility criteria.  
28

1        54.    There was pressure on staff to admit patients who did not meet Medicare/Medicaid  
2 criteria, but there was even greater pressure to retain patients whose conditions had improved or who  
3 were, in fact, ineligible for hospice when they were admitted.

4        55.    Once admitted, it was extremely difficult to discharge a patient even when it was clear  
5 that he/she should not be receiving hospice services. Although patient case files were ostensibly  
6 reviewed regularly by an interdisciplinary team consisting of nurses, doctors, social workers and  
7 spiritual counselors, staff was afraid to recommend discharge for any patient. In those few situations  
8 where discharge was actually considered, the case had to be referred to the certification committee.  
9 The certification committee included staff members that were recommending discharge and the SDH  
10 Medical Director. As a practical matter, the Medical Director virtually always declined the discharge  
11 recommendation and that decision was final.

12       56.    A review or audit of patient files will reveal that there was no justification for the  
13 admission or retention of many patients. The files are laden with "creative" misrepresentations  
14 directed by the management in order to "meet" federal and state regulations.

15       57.    Relator and other registered nurses at SDH were directed to be "creative" in  
16 documenting patient records, and particularly in their "recertification summaries." The recertification  
17 summaries documented the need for continuing hospice care. Management and doctors made sugges-  
18 tions to staff about what phrases to use to disguise the fact that a patient was not declining or was even  
19 improving.

20       58.    The geographic areas covered by the hospital were divided into Branches. Each branch  
21 covered a particular geographic area of the county. Relator was assigned to one of the four teams in  
22 the Northwest Branch. Relator's team was known as "Evergreen" and all four of the teams reported to  
23 Northwest Branch Manager Betsy Mustol. Mustol and Team Physician Gary Buckholz coached  
24 Relator and other nurses to document patient records "creatively" so that the patient could remain on  
25 services.

26       59.    One example was a patient, MDLS, who had a diagnosis of chronic obstructive  
27 pulmonary disease (COPD). On one of the patient's recertification summaries Relator wrote that the  
28

1 patient's condition was improving. Specifically she wrote that the patient was gaining weight, had  
2 gone out shopping for Thanksgiving dinner and planned on cooking dinner for her family. The Relator  
3 saw the patient regularly, and it was clear to Relator that the patient's condition was improving. Dr.  
4 Buckholz suggested to Relator that the patient record should falsely reflect that the weight gain was  
5 because the patient was "retaining fluid" - which does not indicate improvement.

6 60. The Relator and other nurses were regularly encouraged at interdisciplinary meetings  
7 and on recertification summaries to falsify documentation so that patients could remain on Hospice  
8 care. On several occasions when Relator refused to accept the "suggested changes" and falsify the  
9 records, Mustol would actually write the recertification summaries for Relator's patient despite having  
10 no personal contact with the patient.

11 61. Mustol also falsified summaries for other nurses who refused to falsify the records. In  
12 one of the nurses' meetings where Mustol was coaching Relator and the other nurses in attendance to  
13 "creatively" word the recertification summaries, Keith Peyton, R.N. asked sarcastically: "what is this, a  
14 creative writing class?"

15 62. Mustol had access to the MISYS record system and could alter the nurses' entries when  
16 a nurse refused to be "creative" and falsify patient records.

17 63. Every patient day billed to Medicare/Medicaid and other government health care  
18 programs by SDH for patients who did not meet the admission criteria or who were improperly  
19 retained was a false claim under the FCA and California FCA.

20 64. Each falsified patient record and Recertification Summary was a falsified document  
21 which constituted a violation of the FCA and California FCA.

22 65. In 2009 Relator began to voice her concerns about the admission and retention of  
23 patients who were not terminally ill and otherwise did not meet hospice eligibility criteria. Her  
24 complaints to management were ignored.

25 66. On March 1, 2010, Relator sent an email to Jan Cetti, who was then the Chief Executive  
26 Officer of SDH. In the email Relator voiced her concerns, which were shared by other members of the  
27 Evergreen team. Cetti then called a meeting of the team. Team members Jeri Stoner, MSW; Kathy  
28

1 Valdevia, Spiritual Counselor, Relator and possibly Carol Andrews CHHA (certified home health aide)  
2 attended and voiced concerns about the improper admission and retention practices. SDH management  
3 made no changes to these policies despite the meeting.

4 67. On August 9, 2010, Relator met with Mustol and Human Resources personnel. She was  
5 given a "Corrective Action Form" for "persistent negativity which is affecting the Northwest Branch."  
6 The final warning encapsulated the problem. It said, in part, that Relator's "disagreement with  
7 SDHIPM's philosophy of admission criteria" was one of the bases for her discipline. The Corrective  
8 Action document also refers to Relator's negative comments about SDHIPM's policies as relates to  
9 patients' hospice appropriateness."

10 68. As a result, Relator was removed from patient care and transferred to the Admissions  
11 department. She was terminated shortly thereafter, on January 10, 2011. One reason provided in her  
12 written termination letter was "Openly and consistently disagreeing with San Diego Hospice treatment  
13 and practice philosophies."

14 69. In February of 2011, Relator contacted Carol Littler of the California Department of  
15 Human Services to express her concerns about the illegal admission and retention policies at SDH.  
16 Relator was encouraged to submit an "anonymous" letter reporting her observations. Relator provided  
17 this letter on March 24, 2011.

18 70. In January 2012, Relator was contacted by Federal Investigators including FBI Special  
19 Agent [REDACTED] who debriefed her at length. She subsequently met with federal investigators  
20 and Department of Justice personnel.

21 71. Patients for whom false claims were submitted include, but are not limited to, the  
22 following whose names were provided by Relator to the government investigators in March 2011.  
23 Only the initials of these patients are listed below.

- 24 • [REDACTED]
- 25 • [REDACTED]
- 26 • [REDACTED]
- 27 • [REDACTED]
- 28

1 • [REDACTED]

2 72. An investigation and audit was conducted as a result of the information provided by  
3 Relator. In November 2012, Pacurar admitted that doctors and care givers operated for decades on an  
4 "open access" policy that kept patients on hospice care for longer than six months, sometimes without  
5 being able to demonstrate that their condition was worsening. She admits that: "We lost sight of  
6 interpreting these guidelines appropriately. We put the concept of patients, and what we were doing  
7 for them above what the guidelines were."

8 73. Pacurar claimed that the audit was a "wake up call." Pacurar failed to disclose that  
9 Relator, who had opposed the illegal practices, had been terminated and silenced.

10 74. As a result of the fraudulent policies and practices of SDH, false claims were submitted  
11 and caused the government to pay out funds that they otherwise would not have paid, unlawfully  
12 enriching the Defendant.

13 **IX. CAUSES OF ACTION**

14 **COUNT I**

15 **FALSE CLAIMS ACT**  
16 **FALSE CLAIM FOR PAYMENT OR APPROVAL**  
**31 U.S.C. § 3729(a)(1)(A) and (C) (2010)**

17 75. Relator repeats and realleges each allegation contained in paragraphs 1 through 74,  
18 above as if fully set forth herein.

19 76. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §  
20 3729, *et seq.*, as amended.

21 77. Defendant, by and through its officers, agents, employees, related companies, subsidi-  
22 aries and holding companies, knowingly presented, or caused to be presented, a false or fraudulent  
23 claim for payment or approval in violation of 31 U.S.C. § 3729(a)(1)(A)(2010).

24 78. Defendant, by and through its officers, agents, and employees, authorized and  
25 encouraged the actions of its various officers, agents, and employees to take the actions set forth  
26 above.

1       79. As a result of the acts of Defendant, the United States Government reimbursed the  
2 Defendant and other physicians and hospitals for medically unnecessary hospice care, services, and per  
3 diems that it otherwise would not have paid.

4       80. Every statement, billing and claim for payment submitted to the federal health insurance  
5 programs for each and every hospice patient who was not terminally ill with a prognosis of six months  
6 or less to live if the illness runs its usual course, or who was improperly retained in hospice without  
7 meeting government hospice eligibility criteria, represents a false or fraudulent claim for payment.

8       81. By reason of Defendant's acts the United States has been damaged, and continues to be  
9 damaged, in a substantial amount to be determined at trial. Federal health insurance programs have  
10 paid for thousands of days of hospice care and costs that they otherwise would not have paid for but  
11 for Defendant's fraudulent and illegal conduct.

12       82. As set forth in the preceding paragraphs, Defendant has knowingly violated 31 U.S.C. §  
13 3729 *et seq.* and have thereby damaged the United States Government. The United States is entitled to  
14 three times the amount by which it was damaged, to be determined at trial, plus a civil penalty of not  
15 less than \$5,500 and not more than \$11,000 for each false claim submitted, paid or approved.

16       WHEREFORE, Relator respectfully requests this Court enter judgment against Defendant, as  
17 follows:

- 18       (a) That the United States be awarded damages in the amount of three times the damages  
19 sustained by the United States because of the false claims alleged within this Complaint,  
20 as the Federal Civil False Claims Act, 31 U.S.C. § 3729 *et seq.* provides;
- 21       (b) That civil penalties of \$11,000 be imposed for each and every false claim that  
22 Defendant caused to be presented to the Government Healthcare Programs under the  
23 Federal False Claims Act;
- 24       (c) That pre- and post-judgment interest be awarded, along with reasonable attorneys' fees,  
25 costs, and expenses which the Relator necessarily incurred in bringing and pressing this  
26 case;
- 27  
28

- 1 (d) That the Relator be awarded the maximum amount allowed pursuant to the Federal  
2 False Claims Act; and  
3 (e) That the Court award such other and further relief as it deems proper.  
4

## 5 COUNT II

### 6 FALSE CLAIMS ACT 7 FALSE RECORDS OR STATEMENTS 8 31 U.S.C. §3729(a)(1)(B) and (C) (2010)

9 83. Relator repeats and realleges each allegation contained in paragraphs 1 through 74,  
10 above as if fully set forth herein.

11 84. This is a claim for treble damages and penalties under the False Claims Act, 31 U.S.C. §  
12 3729, *et seq.*, as amended.

13 85. Defendant, by and through its officers, agents, employees, related companies, subsidi-  
14 aries and holding companies, knowingly made, used, or caused to be made or used, false records or  
15 statements material to a false or fraudulent claim in violation of 31 U.S.C. § 3729(a)(1)(B) (2010).

16 86. As set forth in the preceding paragraphs, Defendant's provision of hospice care to  
17 unqualified patients defrauded the United States by getting false and/or fraudulent Medicare and other  
18 Government health care claims paid in violation of 31 U.S.C. § 3729(a)(1)(C) (2010).

19 87. Defendant, by and through its officers, agents, and employees, authorized and  
20 encouraged the actions of its various officers, agents, and employees to take the fraudulent actions set  
21 forth above.

22 88. As a result of the acts of Defendant the United States Government reimbursed  
23 Defendant for hospice care that it otherwise would not have paid.

24 89. Every statement, billing and claim for payment submitted to the federal health insurance  
25 programs for each and every patient who received hospice care which failed to meet the admission and  
26 retention rules and criteria was medically unnecessary and represents a false or fraudulent statement.

27 90. By reason of Defendant's acts, the United States has been damaged, and continues to be  
28 damaged, in a substantial amount to be determined at trial.

91. As set forth in the preceding paragraphs, Defendant has knowingly violated 31 U.S.C. § 3729 *et seq.* and has thereby damaged the United States Government. The United States is entitled to three times the amount by which it was damaged, to be determined at trial, plus a civil penalty of not less than \$5,500 and not more than \$11,000 for each false claim submitted, paid or approved.

WHEREFORE, Relator respectfully requests this Court enter judgment against Defendant, as follows:

- (a) That the United States be awarded damages in the amount of three times the damages sustained by the U.S. because of the false claims alleged within this Complaint, as the Federal Civil False Claims Act, 31 U.S.C. § 3729 *et seq.* provides;
- (b) That civil penalties of \$11,000 be imposed for each and every false claim that Defendant(s) caused to be presented to the Government Healthcare Programs under the Federal False Claims Act;
- (c) That pre- and post-judgment interest be awarded, along with reasonable attorneys' fees, costs, and expenses which the Relator necessarily incurred in bringing and pressing this case;
- (d) That the Relator be awarded the maximum amount allowed pursuant to the Federal False Claims Act; and
- (e) That the Court award such other and further relief as it deems proper.

**COUNT III**

**CALIFORNIA FALSE CLAIMS ACT**  
**Cal. Gov't Code §§ 12651(a)(1) and (2)**

92. Relator, acting in the name of and on behalf of the State of California, restates and realleges each and every allegation contained in paragraphs 1 through 74 above as if each were stated herein in its entirety and said allegations are incorporated herein by reference.

93. This is a claim for treble damages and penalties under the California False Claims Act.

94. By virtue of the acts described herein, Defendant, for the purpose of defrauding the California State Government, knowingly presented, or caused to be presented false or fraudulent

1 claims for payment or approval under Medicaid and other California State funded programs, and made,  
2 used and caused to be made and used false records and statements material to false claims.

3 95. Each claim for payment for an inadmissible hospice patient, or a patient who no longer  
4 qualified for hospice care or whose records were falsified represents a false or fraudulent claim for  
5 payment.

6 96. Each claim for payment for hospice care that contained false, inaccurate or deceptive  
7 billing codes or other false statements constitutes a false or fraudulent claim because such false claims  
8 are not covered by the California Medicaid program and other State health care programs.

9 97. The State of California, by and through the California Medicaid program and other  
10 State health care programs, was unaware of the falsity of the records, statements and claims made or  
11 caused to be made by the Defendant and paid and continues to pay the claims that would not be paid  
12 but for Defendant's wrongful actions and omissions.

13 98. As a result, California state monies were lost through payments made in respect of the  
14 claims and other costs were sustained by the California State Government.

15 99. Therefore, the California State Government has been damaged in an amount to be  
16 proven at trial.

17 100. Additionally, the California State Government is entitled to the maximum penalty of  
18 \$10,000 for each and every false and fraudulent claim made and caused to be made by Defendant and  
19 arising from Defendant's conduct as described herein.

20 101. Relator is a private citizen with direct and independent knowledge of the allegations of  
21 this Complaint, who has brought this action pursuant to Cal. Gov't Code § 12652(c) on behalf of  
22 herself and the State of California.

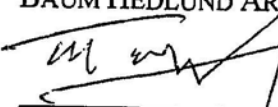
23 102. This Court is requested to accept pendant jurisdiction over this related state claim as it  
24 is predicated upon the same exact facts as the federal claim, and merely asserts separate damages to the  
25 State of California in the operation of its Medicaid program.

26 WHEREFORE, Relator respectfully requests this Court enter judgment against Defendant, as  
27 follows:  
28

- 1 (a) State of California be awarded damages in the amount permitted by law;
- 2 (b) That civil penalties of \$10,000 be imposed for each and every false claim that Defen-
- 3 dant caused to be presented to the State's Medicaid or other Government Healthcare
- 4 Programs under the California False Claims Act;
- 5 (c) That pre- and post-judgment interest be awarded, along with reasonable attorneys' fees,
- 6 costs, and expenses which the Relator necessarily incurred in bringing and pressing this
- 7 case;
- 8 (d) That the Relator be awarded the maximum amount allowed pursuant to the California
- 9 False Claims Act; and
- 10 (e) That the Court award such other and further relief as it deems proper.

11 Dated: December 3, 2012

BAUM HEDLUND ARISTEI & GOLDMAN, P.C.

12   
13 \_\_\_\_\_  
14 Mark Schlein  
15 Diane Marger Moore  
16 Bijan Esfandiari

Attorneys for Relator, Lori A. Rachac

17 **DEMAND FOR JURY TRIAL**

18 Pursuant to Rule 38 of Federal Rules of Civil Procedure, Plaintiffs and Relator hereby demand  
19 a trial by jury.

20 Dated: December 3, 2012

BAUM HEDLUND ARISTEI & GOLDMAN, P.C.

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22 \_\_\_\_\_  
23 Mark Schlein  
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